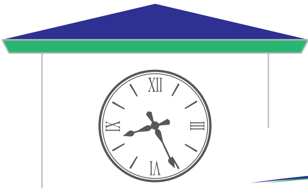

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Family Dentistry

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Patient Information and Medical History Form

Patient's Name (First Name, Middle Initial, Last Name) ____________________

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Cell Phone ____________ Work Phone____________

E-mail ____________ Birth Date ____________ Age ______ Gender ______

Marital Status ______ Spouse's Name ____________ Children ______

Social Security #____________ Occupation ____________

In case of emergency, notify ____________________

Relationship to Patient ____________ Phone ____________

Address ____________ City ____________ State ______ Zip ______

Are you covered by dental insurance? ○ Yes ○ No

If no insurance, how do you intend to pay: ○ Cash ○ Credit Card ○ CareCredit

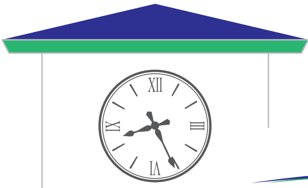
Primary Dental Insurance:

Insurance Company Name:____________________

Is it through your Employer? ○ Yes ○ No Employer Name:____________

Subscriber SS#:____________ Subscriber Birth Date:____________

Group #:______ Insurance Company Address:____________



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1) Are you in good health? ○ Yes ○ No

2) Have there been any changes in your general health with in the past year? ○ Yes ○ No

3) Are you under the care of a physician? ○ Yes ○ No
If yes, please explain: ______________________________
The name and address of my physician ______________________________

4) Are you taking any medications, including non-prescription, herbal supplements, or controlled substances? ○ Yes ○ No
If so, please list : ______________________________
____
____

5) Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphonates (oral or intravenously)? ○ Yes ○ No

6) Do you have any damaged heart valves or artificial heart valves? ○ Yes ○ No

7) Have you had any joint replacements (knee, hip, shoulder)? ○ Yes ○ No
If so, when: ______________________________

8) Have you been instructed to take a pre-medication prior to dental treatment? ○ Yes ○ No

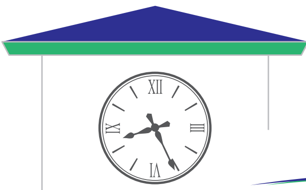
9) Do you use tobacco? ○ Yes ○ No
If so, how much: ______________________________

Allergies:

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Local anesthetics ○ Acrylic
○ Metal ○ Latex ○ Sulfa drugs ○ Other

If yes, please explain: ______________________________
____



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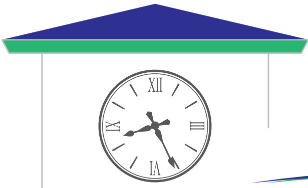
Do you have, or have you had any of the following?

Condition	Response	Condition	Response
AIDS/HIV Positive	O Yes O No	Heart Pace Maker	O Yes O No
Alzheimer's Disease	O Yes O No	Heart Trouble /Disease	O Yes O No
Anemia	O Yes O No	Hemophilia	O Yes O No
Angina	O Yes O No	Hepatitis	O Yes O No
Arthritis/ Gout	O Yes O No	High Blood Pressure	O Yes O No
Artificial Heart Valve	O Yes O No	Hives or Rash	O Yes O No
Artificial Joint	O Yes O No	Hypoglycemia	O Yes O No
Asthma	O Yes O No	Irregular Heartbeat	O Yes O No
Autoimmune Disease	O Yes O No	Kidney Problems	O Yes O No
Blood Disease	O Yes O No	Leukemia	O Yes O No
Blood Transfusion	O Yes O No	Liver Disease	O Yes O No
Breathing Problems	O Yes O No	Low Blood Pressure	O Yes O No
Bruise Easily	O Yes O No	Lung Disease	O Yes O No
Cancer	O Yes O No	Mitral Valve Prolapse	O Yes O No
Chemotherapy	O Yes O No	Pain in Jaw Joints	O Yes O No
Chest Pains	O Yes O No	Parathyroid Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Psychiatric Care	O Yes O No
Congenital Heart Disorder	O Yes O No	Radiation Treatments	O Yes O No
Cortisone Medicine	O Yes O No	Recent Weight Loss	O Yes O No
Diabetes	O Yes O No	Renal Dialysis	O Yes O No
Drug Addiction	O Yes O No	Rheumatic Fever	O Yes O No
Easily Winded	O Yes O No	Sexually Transmitted Disease	O Yes O No
Emphysema	O Yes O No	Shingles	O Yes O No
Epilepsy or Seizures	O Yes O No	Sickle Cell Anemia	O Yes O No
Excessive Bleeding	O Yes O No	Sinus Trouble	O Yes O No
Excessive Thirst	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Fainting Spells	O Yes O No	Stroke	O Yes O No
Frequent Coughs	O Yes O No	Swelling of Limbs	O Yes O No
Frequent Headaches	O Yes O No	Thyroid Disease	O Yes O No
Glaucoma	O Yes O No	Tonsillitis	O Yes O No
Hay Fever	O Yes O No	Tuberculosis	O Yes O No
Heart Attack / Failure	O Yes O No	Tumors or Growths	O Yes O No
Heart Murmur	O Yes O No	Ulcers	O Yes O No



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Have you ever had any serious illness not listed previously? If yes, please explain: ________________

____

____

____

Women:

1) Are you pregnant? ○ Yes ○ No

2) Are you nursing? ○ Yes ○ No

3) Do you take birth control pills? ○ Yes ○ No

Comments: ____

____

____

____

When was your last visit to the dentist? ______________________________

What is the reason for your visit today? ______________________________

____

____

Whom may we thank for your referral? ______________________________

Signature of PATIENT, PARENT, or GUARDIAN ______________________________

Date: __________________